June 10, 2003

MDR Tracking #: M2-03-0671-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 52-year-old woman injured while pulling a fully loaded cart. She felt lob back, mid back and left shoulder pain. Though treated for several weeks, she continued to have back pain. An MRI of the lumbar spine dated March 28, 2000 identified an L5/S1 disc desiccation. She had an MRI of the left shoulder that showed a tiny effusion within the rotator cuff. ___ saw the patient and diagnosed cervicothoracic and lumbar sprain/strain and left shoulder sprain/strain. ___ evaluated her on April 14th and was of the opinion that she had impingement of the shoulder and gave her an injection in the shoulder that provided good relief. In a chiropractic peer review, ___ did not feel that there was documentation to support a significant soft tissue injury and limited the care to 24 visits. ___ entered work hardening in June of 2000. ___ placed her at MMI in July of 2000 and gave her a 5% whole person impairment. She was seen by ___ who treated her with ice and work hardening through September of 2001.)___ saw her and recommended epidural steroid injections. She had a discogram in October of 2000 that identified a normal L3/4, abnormal L4/5 and left posterior lateral fissuring and marked degenerative changes at L5/S1. She underwent surgery in March of 2001, bilateral lumbar laminectomy L4/5 and L5/S1 with interbody fusions at both levels, and posterolateral fusions with screws and rods. She had a peer review by ___ dated November 27, 2002. She underwent a series of lumbar ESIs. On 3/11/02 she was determined to be at MMI statutorily and was given an 18% whole person impairment. ___ has requested an Orthotrac Pneumatic Vest to increase her functional capabilities, and this request was denied as being medically unnecessary.

REQUESTED SERVICE

The purchase of an Orthotrac Pneumatic Vest is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The treating doctor proposed the use of the device but did not provide any clinical information of prior treatments that offloaded the lumbar spine, treatments that would have demonstrated a benefit to obtaining this device. There is no clinical data to support the use of this device.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).